

alzheimer's association®
Midlands Chapter

1941 S. 42nd Street, Suite 205
 Omaha, NE 68105

Business Phone: 402.502.4301 or 800.272.3900

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24/7 Contact Center: 800.272.3900

www.alz.org/midlands

For Office Use Only			
Date:	Initialed By: DG CF		\$ Amount:
Application Form Complete:			
Physician Statement Complete:			
Call or E-mail of Acceptance:			
Receipts Received:			
Reimbursement Authorized:			
Receipts Received:			
Reimbursement Authorized:			
Receipts Received:			
Reimbursement Authorized:			
Receipts Received:			
Reimbursement Authorized:			

Application Form for Respite Care Reimbursement—2012

Purpose:

This program seeks to provide reimbursement for respite services for caregivers of a person disabled with Alzheimer's disease or other dementias. Respite service funding is intended for adult day services, in-the-home respite care, or short-term placement in a care facility.

Eligibility:

- Completed Application Forms will be considered.
- Recipients may not be on Medicaid or recipients of other Alzheimer's grants.
- Individuals with the dementing disorder must reside in Douglas and Sarpy Counties.
- Individuals with the dementing disorder must reside primarily in their home setting.
- Physician statement of diagnosis of the dementing disorder must be provided.
- Relatives or members of the same household do not qualify for care provider reimbursement.

Reimbursement Guidelines:

- The primary caregiver is responsible for selection, arrangements for service and payment of the respite provider.
- In home respite care and/or companionship must be provided by reputable homecare provider.
- **Up to a maximum of \$780** may be provided during the grant period—**January 15th thru October 31, 2012** or until funds are depleted.
- The primary caregiver must submit proof of payment for the respite service to the Midlands Chapter office—checks and copies of receipts for payment, etc.
- Only complete reimbursement requests will be considered for payment.
- **Reimbursement is made at the Chapter Office. Checks will be mailed if receipts are accompanied by a self-addressed stamped envelope. Checks will be drafted in amounts of \$200.00 or greater during the month following submission of proof of payment.**

Please provide all of the information requested below—Reimbursement will be expedited when both sides of this form are completed and returned to the Chapter office. PLEASE PRINT

Primary Caregiver Name: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ E-mail: _____

Name of Individual with dementia: _____ Age: _____

Relationship of Individual to Primary Caregiver: _____

Gender: _____ Race: _____ Physician statement is attached: yes ___ no ___

Annual pre-tax income ranges—*please check one*: Under \$20,000 ___ \$20-30,000 ___ \$30-40,000 ___ \$40-50,000 ___ Over \$50,000 ___

The information I have provided above is accurate and I understand and agree to all of the guidelines above.

Signature of Primary Caregiver: _____ Date: _____



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Physician Statement

Please have your physician complete this statement as a part of your Application for Respite Care Reimbursement.
PLEASE PRINT

Name of Individual with dementia: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Caregiver Name: _____

Physician Name: _____


Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Diagnosis: _____

Date of Diagnosis: _____

Physician Signature: _____ Date: _____

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